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THE CENTRE FOR DEFENCE HEALTHCARE ENGAGEMENT – A FOCUS FOR DEFENCE ENGAGEMENT BY THE DEFENCE MEDICAL SERVICES – PRE-PRINT

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Abstract

The 2015 Strategic Defence and Security Review (SDSR) committed the government to an ambitious programme of Defence Engagement. This paper provides a short summary of the medical contribution to UK Defence Engagement. It then describes the intentions behind the creation of the Centre for Defence Health Engagement.

Key Words

International health services < HEALTH SERVICES ADMINISTRATION &
MANAGEMENT
MEDICAL EDUCATION & TRAINING
PUBLIC HEALTH

INTRODUCTION

The 2015 Strategic Defence and Security Review (SDSR) committed the government to an ambitious programme of Defence Engagement (DE) (1). Defence Engagement is the means by which the UK uses Defence assets and activities, short of combat operations, to achieve influence (2). DE for Defence will both increase our collaboration with existing partners and allies, and also reinforce our efforts to build the capacity and willingness of nations to address global security concerns at their source. Defence Healthcare Engagement is the use of UK military medical capabilities to achieve DE effects in the health sector. The SDSR specifically announced the creation of a new Centre for Defence Healthcare Engagement (CDHE) to share UK defence medical best practice with allies and partners (3). In this paper we describe

the role of the UK Defence Medical Services (DMS) in defence health engagement, and how this will be supported by the CDHE in health sector capacity building with partner nations' security sectors.

DEFENCE HEALTHCARE ENGAGEMENT

Defence engagement activities can occur across the spectrum of conflict from health systems strengthening as part of preventing conflict, during conflict to maximise the effectiveness of the health system of allies and partners, and after conflict to support the creation security and stability (4). Healthcare to non-military beneficiaries is a key deliverable for the security services in many emerging and low income countries, a situation that is less common amongst high income countries. Therefore Defence healthcare engagement may contribute to building the conversation about wider development of the whole health sector in an overseas country. This can contribute to wider UK national goals in global health (5). Thus the nature of capacity building in health services created by Defence healthcare engagement through the security sector can contribute to wider strategic policy objectives in the diplomatic, and economic instruments of national power beyond purely military policy objectives (6).

Defence healthcare engagement needs to build upon previous experience and lessons learned. In Afghanistan, the UK initially delivered first aid training for Afghan National Army and Afghan National Police personnel in Helmand (7). However, the key transformation occurred when NATO supported the requirement for the Afghan 205 Corps in Helmand to have a regional level referral hospital in which to admit their security forces casualties after NATO forces departed from Helmand. The last 18 months of the UK campaign in Helmand required a medical mentoring program to enable the Afghan army hospital in Camp Shorabak to deliver this medical capability. Whilst ultimately successful, there was difficulty in maintaining a program of mentoring and partnership across each operational rotation because of the lack of institutional knowledge in this field (8).

The DMS contribution to the Ebola response in Sierra Leone is also another example (9). In the first phase the DMS supported the surge of indigenous health care capacity by running training programs for the use of personal protective equipment by healthcare workers. In the second phase medical support contributed to the moral component of the international response by providing access to international quality healthcare services for both Ebola, and disease and non-battle injury. Transition to indigenous capacity was based upon handing over the military Ebola treatment unit to the civilian sector and using DMS skills to support the development of the Royal Sierra Leonean Armed Forces rapid deployable infectious disease capability.

However, this narrative of short-term reactive engagement by international military medical staff with local military and civilian actors is insufficient to capture the challenges of persistent and long-term partnerships for capacity building. Instead a more sophisticated narrative focusing on the unique role of DMS in contributing to the development of partner security services medical services is beginning to emerge. This may include police and prison services as well as armies. There are no other international agencies or NGOs for which this segment of a national health sector is a natural focus of capacity building activities. This emphasis can contribute directly to the stabilisation effect of creating indigenous security capacity for peace making and peace keeping. Contemporary instability and conflicts in emerging and low income countries is increasingly being managed or supported by local and regional security sector forces. Therefore the DMS also needs to consider how to support

military medical capacity building at a regional level using our experiences of working within coalitions and alliances. Finance for security sector health services usually come out of the Defence Ministry budget which tends to be disproportionately great during periods of tension in security, and therefore the UK DMS can have an indirect effect on raising quality across the local health sector but without actually having an effect in 'humanitarian space' (10).

There are potential philosophical issues associated with the use of international military medical services in the civilian health sector. Most high income military medical services recognise the concept of humanitarian space and the importance of a clear distinction between military forces and civilian healthcare providers or NGOs in complex emergencies. It is therefore essential that DMS engagement in the health space is sensitive to the local political situation, and should respect the importance of separating the civilian health sector from security related issues. Although the concept for stabilisation operations includes the provision of basic services as a critical component to building consent for the contested support of the civilian population, care is needed to make sure that civilian health services themselves do not become an instrument in the conflict. There is a need for deep conceptual recognition of these issues by all actors in the health and humanitarian space. The salient totemic issue surrounds the use of international military forces to provide direct, non-urgent medical care with the civilian population (MEDCAPS, 11). This needs approaching with sensitivity, and only as an agent of last resort (12).

The DMS needs to ensure that our people are provided with appropriate ethical and cultural frameworks. In the hospital in Camp Bastion it was necessary to adjust the clinical intention for Afghan casualties compared to Western European and NATO casualties (13). As a practical example, it might have been correct to make an early decision for amputation for an Afghan with a severe lower limb injury rather than considering a long programme of limb reconstruction that might be possible for a British casualty. The most challenging aspects may lie within local nursing cultures. In many healthcare systems, nurses have no role in personal care for patients as that is done by relatives. Yet in the security sector there are no relatives available to look after patients so it may be necessary to have some challenging discussions with nurses to remind them their duties in terms of provision of personal care for patients who cannot do this for themselves. There may also be challenges with the standard of nursing observations and records. Thus we may have to sensitise our people to some of the realities of caring for patients in a resource-constrained environment at a level that they will not have experienced in the UK. It can be very distressing to watch somebody die of a condition that you are perfectly competent to care for yourself but for which local clinical staff may not have the tools, techniques or equipment.

THE CENTRE FOR DEFENCE HEALTHCARE ENGAGEMENT

In light of the changing nature of conflict, the humanitarian space and the rapid rise of the security sector in delivering health in many emerging and low-income countries, the DMS needs greater capability and capacity in teaching and learning about global health. The UK's Centre for Defence Healthcare Engagement is the start of an approach aimed at networking knowledge, capability and capacity in global health between security and civilian sectors. It will help the DMS to build a cadre of people who have a professional interest in this field to provide a system level perspective on healthcare engagement with overseas security sectors. This will set a more strategic approach to global health within the Armed Services and between the security sector, civilian domestic, and international partners. The United Kingdom is unique as there are no military hospitals. However there are close relationships

between the National Health Service and the Defence Medical Services to coordinate hospital care for armed forces personnel. It may be possible to use this collaboration as part of the Defence healthcare engagement proposition both in UK and in the country of engagement. Part of this effort might be to facilitate and signpost some of the very high quality, internationally recognised, civilian health sector education systems that we have in the United Kingdom. The goal is to match the range of tools that the UK has available against the range of needs that are present in a partner country and focussing our national tools to those needs that are going to have the greatest strategic impact.

Defence engagement is a core task for the DMS and therefore we need to embed the skills to deliver it as part of core activity and core knowledge. There are some basic principles and skills that need to be part of the military medical education system. The DMS also needs to look at the deeper educational needs for people who are going to lead and manage the approach. The CDHE will look at where that knowledge is held and how it is communicated just as would be done with any other technical aspect in medicine. The DMS Military Humanitarian and Stabilisation Operations Course provides specific generalist education in this field. Above this level, the CDHE will examine the methods for postgraduate education and advanced 'clinical experience' in this field so a small number of people will have the opportunity to develop Defence Engagement as an additional career field.

The investment into the Centre for Defence Healthcare Engagement needs to be underpinned by the development of performance measures and measures of effectiveness. Some of these will be soft but then many of the foreign policy objectives under which we may operate are very difficult to measure. It is also possible to have some hard targets. As a practical example, in our engagement with Pakistan, our unique contribution could be about contributing to their internal debate about the role of nurses. This is exactly the theme of a recent report on how investing in nursing will improve health, improve gender equality and support economic growth (14). The Pakistan military medical services has also developed an employment pathway for 'Lady Doctors' in response to the large number of female graduates from medical schools. The DMS engagement programme can also support the role of women in the delivery of healthcare in the Armed Forces medical system. The DMS impact on the Armed Forces medical system can be extrapolated into a 'change agent' role in the wider Pakistan health sector. Thus Defence health engagement can have a role to play in wider upstream capacity building because of the relatively non-contentious nature of military medicine compared to other military activities.

CONCLUSION

The establishment of the Centre for Defence Healthcare Engagement is an exciting opportunity to formalise the knowledge in the Defence Medical Services for health sector capacity building with partner security services. The CDHE will codify our learning from previous military medical engagement activities. It will become the repository for our knowledge and will develop the DMS educational programmes to ensure that this is transferred across individual experiences. The CDHE will build partnerships with national stakeholders in global health to help set conditions for collaborative work between military and civilian capacity-building activities in countries of mutual interest. It will also establish and deepen formal relationships with international and global organisations particularly focussing on establishing performance measures of effectiveness.

Word Count 1931

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